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Office of Administrative Law Judges
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Issue Date: 30 September 2004

CASE NO. 2003-LHC-1646
OWCP NO. 1-151470

In the Matter of

RICKY V. WILCOX,

Claimant,

v.

ATKINSON CONSTRUCTION COMPANY,

Employer,

and

THE TRAVELERS INSURANCE COMPANY,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES[1]:

Janmarie Toker, Esq.
McTeague Higbee
Topsham, Maine
For the Claimant

Richard Van Antwerp, Esq.
Robinson, Kriger & McCallum
Portland, Maine
For the Employer

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[1] The Director, Office of Workers' Compensation Programs was not represented by counsel at the hearing.

BEFORE: DANIEL J. ROKETENETZ
Administrative Law Judge

DECISION AND ORDER - AWARD OF BENEFITS

This case arises from a claim for benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, *et seq.* (hereinafter referred to as either LHWCA or the Act). This case was referred to the Office of Administrative Law Judges by the Office of Workers' Compensation Programs for a hearing. Following proper notice to all parties, a formal hearing in this matter was held on June 18, 2003, in Portland, Maine. Exhibits of the parties were admitted at the hearing pursuant to 20 C.F.R. § 702.338 and the parties were afforded the opportunity to present testimonial evidence as provided in the Act and the regulations issued thereunder and to submit post-hearing briefs.

The findings of fact and conclusions of law set forth in this Decision and Order are based on my analysis of the entire record. Each exhibit and argument of the parties, although perhaps not mentioned specifically, has been carefully reviewed and thoughtfully considered. References to EX. 1 through 9, and CX. 1 through 43 pertains to the exhibits admitted into the record and offered by the Employer and the Claimant, respectively. The transcript of the hearing is cited as Tr. followed by page number.

STIPULATIONS:

1. The Act, 33 U.S.C. § 901 *et seq.*, applies to this claim;

2. The Claimant and the Employer were in an employee-employer relationship at the time of the injury;

3. The accident/injury occurred on November 16, 2000.

4. The Claimant gave the Employer timely notice of his injury;

5. The Claimant's claim was filed in a timely fashion;

6. The Employer filed timely notice of contraversion of this claim;

7. Travelers paid temporary total benefits from November 27, 2000 through July 21, 2002;

8. Travelers paid a permanent partial disability of 12% to Mr. Wilcox's arm. Payments were made on a weekly basis over approximately 37.4 weeks from July 22, 2002 to April 11, 2003; and,

9. The Claimant's average weekly wage is $1001.14.

ISSUES:

The issues in this case are:

1. Whether Mr. Wilcox's condition has reached Maximum Medical Improvement;

2. The nature and extent of Mr. Wilcox's work-related injury;

3. Medical bills; and,

4. Attorney fees.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

The Claimant, Ricky V. Wilcox, was thirty-nine years old at the time of the hearing. (Tr. 23). He is married with two children who were ages three and five at the time of the hearing. (Tr. 23-24). Mr. Wilcox is a high school graduate. (Tr. 23). After high school, the Claimant worked in residential and commercial construction as a carpenter, generally working on condominium projects and larger commercial jobs. (Tr. 24). He joined the Carpenters' Union in 1998, and the union assigned work to Mr. Wilcox from the union hall. (Tr. 24). On April 18, 2000, the Claimant started work through the union at Atkinson's project at the BIW site. (Tr. 24-25). The Claimant remained continuously employed at the BIW site until November 16, 2000, when he went out of work due to the work related injury that is the subject of this claim.

The Claimant avers that the injury to his arm and the accompanying sequalae occurred on November 16, 2000, while he was preparing a slab to be poured in the construction of a dry

dock. (Tr. 28). On November 16, 2000, he was installing a static line for a crane rail as part of the slab preparation. (Tr. 28). A static line is a 20 foot piece of metal, 6 inches wide and 1/2" thick with flat rebar hooks. (Tr. 28). The line is put in place and then the electricians follow behind and tie electrical ground wires to the metal. (Tr. 28). Each of these metal pieces weighs approximately 200 pounds. (Tr. 29). The Claimant testified that his partner, Matt, was a large man who could reach down and pick up his end of the static line with one arm and stand up with it, while Mr. Wilcox had to hook his elbow under the line and lift with his legs. (Tr. 29). As the Claimant was picking up his end of one static line which was turned over upside down, Matt flipped the line over to the correct side before Mr. Wilcox was prepared to move the line. (Tr. 29). As the static line turned over, one of the rebar hooks went inside the Claimant's left glove, the static line rolled off of his arm, twisting the Claimant's arm away from his body, forcing the Claimant to strike his head during the fall and popping his left elbow out of its joint. (Tr. 30-31). The Claimant testified that he immediately felt pain in his left elbow and shoulder area. (Tr. 32).

The first treatment Mr. Wilcox received was eleven days later, on November 22, 2000, when he was seen by Dr. Knauft at Mid-Coast Hospital Urgent Care. (Tr. 52). Dr. Knauft referred Mr. Wilcox to Dr. Van Orden, an orthopedic surgeon for evaluation. (Tr. 33, 53). The Claimant states that he complained to Dr. Van Orden in the initial November 27, 2000 visit that he was experiencing pain in the elbow, pain from striking his head during the incident, that his neck and shoulder was bothering him and that he was having headaches. (Tr. 35-36, 54). Dr. Van Orden treated the Claimant for several months for extensive tendonitis, giving him cortisone shots in the elbow and prescribing physical therapy. Mr. Wilcox continued to have headaches, pain in the shoulder and neck and intense pain in the elbow. (Tr. 38). Dr. Van Orden determined that surgery would be necessary on Mr. Wilcox's extensor tendon. (Tr. 36). The Claimant engaged Dr. Adams, an orthopedic surgeon, to provide an independent second opinion on the necessity of surgery. (Tr. 57). The insurance carrier had Dr. Dowling, also an orthopedic surgeon, provide a second opinion regarding the necessity of surgery. (Tr. 57). The Claimant had surgery June 20, 2001 on the left elbow. (Tr. 37). After surgery, there was little difference in the pain level. (Tr. 38). As an example, Mr. Wilcox stated that if he tried to swing a hammer in his left (dominant) hand (as he would in his job as a carpenter) he would only be able to swing it a few times

before the pain would bring him to tears. (Tr. 38). After the surgery, the Claimant continued therapy and consultations with Dr. Van Orden every four months until the physical therapist reported to Dr. Van Orden that physical therapy had accomplished as much as was possible. (Tr. 39). After discussion with Dr. Van Orden, the Claimant, who was still suffering pain, sought a second opinion from Dr. Caldwell. (Tr. 42). Dr. Caldwell, in turn, referred the Claimant to Dr. Fitz, who suggested a nerve conduction study to evaluate the radial nerve that runs from the upper arm to the fingertips. (Tr. 42-43). During this injury period, the Claimant has not been prescribed any medication other than over-the-counter pain relievers. (Tr. 51).

At the time of hearing, the Claimant testified that he can no longer swing a hammer without jolting pain running down his arm. (Tr. 44). When he took a position as a dish washer at Simon's Family Restaurant, he could not move an entire rack of dishes at one time, but had to remove a few dishes at a time and carry them down to the dishwasher. (Tr. 45). In the summer, 2003, Claimant quit his job as a dishwasher due to increased pain in his arm, shoulder, neck and continuing headaches. (CX 42, p. 4, 11). The Claimant currently works at his father's clothing apparel and consignment store at a rate of $6.25 per hour. (CX 42, p. 5). The Claimant works behind the counter taking money and answering the phones. (CX 42, p. 6). Mr. Wilcox continues to feel pain with his arm and shoulder, and he continues to have headaches. (CX 42, p. 7). The Claimant is no longer receiving treatment for his headaches, arm or shoulder. (CX 42, p. 10).

The Claimant had a previous work related injury in 1992. He fell through a ceiling while working and landed on his left shoulder. (Tr. 48). The Claimant had tendon surgery on the left shoulder and spent the next year to a year and a half recovering from that surgery and not working. (Tr. 49). After recovery from the 1992 injury, he was able to return to construction work without restrictions. (Tr. 50).

Lay Testimony:

The Claimant's father, Darrell Wilcox, was deposed by the Employer on November 18, 2003. (CX 30). Mr. Wilcox testified that he hired his son at minimum wage to help his son and his son's family out. Ricky greeted customers at his father's business, took cash, occasionally drove a van to pick up employees or to retrieve items from Bangor, Maine for his father's business. When asked what he hired Ricky to do, he

replied "I'm just making a job. That's all I'm doing you know. . . ." When asked why Mr. Wilcox doesn't use Ricky in his wife's cleaning business, Mr. Wilcox testified that "basically, when he [Ricky] gets in these moods, I don't want him around my employees. . . . This [injury] has seemed to get to him mentally. You know, he's a – he's getting so he's explosive. . . . He has days when depression sets in . . . but he's going to a doctor now. They're giving him medications, and it seems to be mellowing him out."

Alden J. Simons, the owner of Simons Family Restaurant, was deposed by the Claimant on November 18, 2003. (CX 31). Mr. Simons testified that he hired the Claimant in March, 2003 to wash dishes at his restaurant. Although Mr. Wilcox was hired as a full time employee and expected to work 40 hours per week, Mr. Simons estimated that the Claimant was only able to complete an average of 28 hours per week. For the other 12 hours per week, Mr. Wilcox would go downstairs and lay down on a couch in the restaurant office in an attempt to relieve his pain from working. Mr. Wilcox was further accommodated by Mr. Simons in that he was not required to carry dish-filled bus buckets like the other dishwashers, nor was he required to empty trash cans or mop floors. Mr. Simons testified that "it got to the point where we finally had to talk and he wasn't working there anymore because – he's a good guy and he wants to work, but he just couldn't do it." Mr. Wilcox worked at the restaurant about three months and was paid around $6.50 per hour.

Diane J. Wilcox, the Claimant's wife, was deposed by the Claimant on November 18, 2003. (CX 32). Mrs. Wilcox testified that the Claimant can't roughhouse with the kids anymore, and if one of the children was to fall asleep downstairs, she has to carry him up because Mr. Wilcox doesn't have the strength to do it anymore. Mrs. Wilcox does all the cleaning around the house because the Claimant can't help anymore. The Claimant does do light dusting around the house. She noted that Mr. Wilcox uses a lot of ibuprofen and a hot rice bag to ease his pain. The Claimant experiences headaches several times per week.

Medical Evidence:

Dr. John S. Van Orden, an orthopedic surgeon, treated the Claimant on November 27, 2000, following his injury. (CX 23, p. 45). Dr. Van Orden noted tenderness over the biceps insertion but the biceps insertion on the left remained intact. He was tender over the extensor origin on the left and experienced pain

with extension of the wrist and the long finger. X-rays were normal. He recommended an exercise program for the Claimant.

On a return visit on December 18, 2000, Dr. Van Orden noted that the bicep tendon was intact distally at the elbow but mildly tender. (CX 23, p. 48). There was more tenderness over the lateral epicondyle. He had a good range of movement of his elbow and he was intact neurovascularly. Dr. Van Orden diagnosed extensor tendonitis with perhaps a strain of the distal biceps. He administered a pain injection to the elbow.

The Claimant returned for treatment on January 8, 2001. (CX 23, p. 50). The Claimant reported that the injection helped with pain and that he had undergone two weeks of physical therapy. He had mild tingling in the long and ring fingers. The Claimant reported that he has not been completing the exercises recommended. The Claimant was unable to swing his usual 23 ounce hammer.

On January 25, 2001, the Claimant reported to Dr. Van Orden that cold weather was causing him stinging and pain in the left elbow and increased symptoms. (CX 23, p. 53). Dr. Van Orden administered a second injection to the lateral epicondyle for pain.

On February 23, 2001, Dr. Van Orden noted increased and more frequent pain in the Claimant's elbow. (CX 23, p. 56). The second injection helped for only a few days. Dr. Van Orden recommended a formal course of physical therapy with ultrasound.

On March 22, 2001, Dr. Van Orden noted that the Claimant seemed to be improving. He continued the treatment in place. (CX 23, p. 59). He released the Claimant to restricted work, lifting no more than 20 pounds, with frequent lifting or carrying not to exceed 10 pounds.

On a return visit on April 9, 2001, Dr. Van Orden noted that the Claimant attempted to change a tire on his car and felt his elbow tear again. (CX 23, p. 61). He injected the extensor origin for pain. If there was no improvement, he stated that he may be a candidate for surgery.

On May 10, 2001, the Claimant reported to Dr. Van Orden that the pain injection helped for only a few days. (CX 23, p. 63). Dr. Van Orden recommended surgical treatment of the Claimant's lateral epicondylitis of his left elbow.

On June 21, 2001, the Claimant underwent the recommended surgery.

On July 23, 2001, Dr. Van Orden noted that Mr. Wilcox was four weeks post-surgery (CX 23, p. 71) with a range of motion 10 to full flexion, good pronation, and supination. The Claimant still had a burning when he did "duck" exercises and was still in a bivalve cast most of the time.

Dr. Van Orden completed a work release on August 14, 2001, limiting the Claimant to sedentary work, lifting 10 pounds maximum and occasional lifting of small items. The Claimant was restricted to occasional walking and standing only. (CX 23, p. 74).

On September 10, 2001, Mr. Wilcox returned to Dr. Van Orden, complaining of pain laterally and anteromedially. (CX 23, p. 78). Dr. Van Orden noted full range of motion of his shoulder and elbow. He recommended a full course of Occupational Therapy.

Dr. Van Orden examined the Claimant again on October 29, 2001. (CX 23, p. 80). The Claimant was still experiencing pain while continuing physical therapy. Dr. Van Orden questioned whether the Claimant will ever be able return to heavy construction work.

The Claimant returned to Dr. Van Orden on December 10, 2001. (CX 23, p. 87). Dr. Van Orden scheduled Mr. Wilcox for a Functional Capacity Examination. On December 20, 2001, the Claimant reported to Dr. Van Orden that he lifted a 28 pound box above his chest level which caused him intense pain. Dr. Van Orden believed that Mr. Wilcox had re-aggravated his extensor tendonitis. He opined that the Claimant would be a good candidate for vocational rehabilitation.

Mr. Wilcox underwent a Functional Capacity Evaluation on December 17, 2001. (CX 25). The tester noted full cooperation throughout the evaluation. The Claimant demonstrated good aerobic capacity and a work ability in the medium category of work (based on U.S. Dept. of Labor standards). The Claimant presented continued post-operative weakness and pain/inflammation. He would have great difficulty working in a sustained cold environment, and would have great difficulty using vibratory tools without further risk of injury. He would require further strengthening, flexibility and endurance exercises to regain functional use of his left upper extremity.

He may benefit from vocational retraining to avoid further stress and injury to his left (dominant) elbow.

Dr. Van Orden authored a January 22, 2002 letter in which he stated that Mr. Wilcox "probably has reached medical endpoint. I think he would be a good candidate for vocational rehab as it is unlikely he is going to get back to using a heavy hammer with his dominant left elbow still being as painful as it is post surgical release of its extensor origin." (CX 23, p. 93).

On a follow up visit on April 5, 2002, Dr. Van Orden noted that the Claimant had a sticking sharp pain laterally that went down to his fingers and up the arm to the traezius and he was having pounding headaches. (CX 23, p. 96). The headaches started some time after the surgery. Physical therapy had not helped. On examination, Mr. Wilcox had a full range of motion in the cervical spine, shoulder and elbow. Dr. Van Orden prescribed a soft cervical collar.

On May 6, 2002, the Claimant reported to Dr. Van Orden that the cervical collar did not appear to offer much help and that his headaches were continuing. (CX 23, p. 97). Dr. Van Orden referred the Claimant to his family doctor to review the etiology of the headaches.

Dr. Nibha Mediratta examined the Claimant on May 7 and May 29, 2002. (CX 22). Dr. Mediratta noted continued left arm discomfort and headaches following recent surgery for tendon repair along the left elbow. Examination of the neck revealed a full range of motion with no midline tenderness. There was some spasm along the sternocleidomastoid and point tenderness just above the cutital fossa above the surgical scar. It was painful for the Claimant to supinate his arm against resistance in that area, but he retained full range of motion in the shoulder joint. Dr. Mediratta recommended further follow-up with Dr. Van Orden.

Dr. Michael Parks, an Ophthalmologist, examined Mr. Wilcox on May 10, 2002, and found no vision-related problems that could induce headaches in the Claimant. (CX 24).

On May 28, 2002, Dr. Van Orden completed several releases, stating that with reasonable medical probability, the Claimant could perform the duties of the employment positions of Host, Job Coach, Customer Service Representative, Flagger, Car Sales, and Dispatcher. (CX 23, pp. 98-105).

In progress notes dated July 8, 2002, Dr. Van Orden noted pain with resistive extension of the wrist and long finger but good strength. (CX 23, p. 107). The elbow was stable. He stated that the Claimant is unlikely to be able to perform repetitive tasks with the left arm.

On July 26, 2002, Dr. Van Orden gave the Claimant a 12% upper extremity permanent impairment rating. (CX 23, p. 109).

On November 5, 2002, Dr. Van Orden noted that the Claimant was experiencing pain going up his left humerus involving his lateral elbow and down to the long and ring finger MP joints, causing neck spasms and headaches. On examination, he noted a full range of movement on the cervical spine, shoulder, elbow and forearm. An x-ray was normal. Dr. Van Orden did not feel that further surgery would help the Claimant.

Dr. Tom Caldwell, Board-certified in Pain Medicine and Physical Medicine and Rehabilitation, examined the Claimant on December 13, 2002 and submitted a written report. (CX 20). He noted the Claimant's work history, a prior left shoulder injury (now fully healed) and current medication of over-the-counter pain relievers. On examination, Dr. Caldwell noted that the Claimant tended to guard the left arm, but gave full effort during testing. The left elbow had a scar consistent with surgery at left epicondyle. His elbow lacked at least 10 degrees of extension. Supination was restricted first by pain and then by actual bony or soft tissue restriction that could not be overcome. The radial nerve was very tender in the distal upper arm, elbow and proximal forearm. The left hand could develop just 80 pounds of strength. There were myofascial findings in the left periscapular region, especially the upper trapezius levator scapulae region and the infraspinatus and rhomboids and slightly in the pectoralis muscles. Range of motion of cervical spine was full, but there was some tension in the left paracervical muscles. He reviewed treatment records with Dr. Van Orden and Dr. Mediratta. A functional capacity assessment was performed in December, 2001, which, in his opinion, demonstrated the ability to work in a medium category of work.

Dr. Caldwell opined that the Claimant's pain was chronic and complicated and involved injury to joint, soft tissue, ligaments, muscles and nerves. There had been no significant improvement after surgery. Dr. Caldwell recommended further assessment by a hand and arm specialist. The Claimant's pain

pattern and some of the physical findings were consistent with radial nerve trauma or at least irritation. The Claimant had an extensor tendonitis or tear at the lateral epicondyle with probable subluxation and injury to the radial head. He opined that the injury to the left elbow has caused the myofascial problems and the headaches. He stated that currently the Claimant is capable of only light to moderate work activity. He opined that the need for further treatment and evaluation precluded a medical endpoint determination.

Dr. David G. Fitz, a hand and arm specialist, examined the Claimant on April 8, 2003. (CX 21). On examination, Dr. Fitz noted a well-healed scar over the left lateral epicondyle with point tenderness at the site of surgery as well as joint tenderness and 2 to 3 cm distal to this over the point of exit of the posterior interosseous nerve. There was significant joint tenderness above the lateral epicondyle within the triceps with pain radiating down into his forearm and wrist. There was pain on resisted extension of his wrist and pain with restricted extension of his left middle finger with pain extending into his forearm. Dr. Fitz diagnosed chronic myositis, chronic tendonitis, and evidence of radial tunnel syndrome. He opined that the Claimant should undergo nerve conduction studies to further evaluate the radial tunnel syndrome.

Dr. Caldwell examined the Claimant a second time on October 30, 2003, and submitted a written report. (CX 29, 41). Dr. Caldwell noted the Claimant's 1992 torn tendon in the left shoulder, which, following surgery, was repaired to the point that he was returned to work without restrictions. On physical examination, Dr. Caldwell noted that the Claimant "has full range of motion in the cervical spine, shoulders, elbows and wrists." He was tender to palpation just above the scar in the area between the biceps and triceps muscle and in the levator scapulae and upper trapezius area. Palpation of the cervical spine seemed to cause some radiation towards the head and was consistent with a headache. Electrodiagnostic tests revealed full functioning. The area of his tenderness and the radiation of his pain was consistent with radial nerve neuralgia, and he had myofascial pain that radiates towards the left eye. Such a pattern of pain is well-documented, *e.g.*, The Myofascial Pain and Dysfunction by Travell and Simons. Utilizing the AMA Guides to the Evaluation of Permanent Impairment, Third edition, table 16, Dr. Cauldwell assigned the Claimant a 15% upper extremity impairment, which translated into a 9% whole person impairment. Dr. Caldwell recommended treatment with a physiatrist to deal with chronic pain. The Claimant cannot work on ladders or

unprotected heights, cannot operate vibratory or power tools and cannot manipulate objects using a repetitive motion.

Dr. Fred Bloom evaluated the Claimant in November, 2003 for depression. (CX 28). Dr. Bloom noted that "[t]he loss of his ability to work in a construction job has been a major financial and psychological catastrophe for Ricky. Psychologically, it has taken away his two main sources of pride, his capacity to do skillful work, and his capacity to provide for his children. His current depression is clearly the result of his work injury and subsequent disability." Dr. Bloom recommended psychotherapy and vocational rehabilitation, "so that he can again become a genuinely productive person."

Dr. Seth Kolkin, a Board-certified Neurologist with a subspecialty of Neurophysiology, examined the Claimant on December 3, 2003. (CX 35). Dr. Kolkin reviewed the circumstances of the accident and the medical records generated in treatment to that point. The Claimant stated that he has a constant, heavy, aching and sore sensation over his left shoulder and at the base of his neck on the left side. During the day, especially when under stress, the pain becomes more severe, radiates into the left occiput and then through to the left eye where he develops severe throbbing headaches. Upon examination, Dr. Kolkin noted a full range of motion. There was no sign of entrapment neuropathy of the radial or posterior interosseus nerve. On neurologic exam, mental status and cranial nerves were normal. Motor testing was normal except MRC weakness in the ulnar hand intrinsics. Wrist extension was inhibited by discomfort. Dr. Kolkin opined that neurological examinations do not reflect neuropathology, and his nerve conduction studies and EMG of the upper left extremity also failed to show any nerve pathology. He agreed with other physicians that the current diagnosis is chronic lateral epicondylitis and tendonitis of the extensor muscles of the forearm. Dr. Kolkin further opined that the Claimant had reached maximum medical improvement and probably reached that point by the time his June 2001 surgery had fully healed, perhaps by October, 2001. He stated:

> Utilizing the Fourth edition of the AMA Guides to the Evaluation of Permanent Impairment, chapter 3, [the Claimant] has no impairment related to a restricted range of motion for the elbow joint. Similarly, there is no neurologic deficit and, therefore, there would be no impairment for motor or sensory changes. His grip strength, as measured at the time of his

> functional capacity evaluation, was actually normal on the left side, but there is a 16% 'strength loss index' comparing the two sides. Utilizing table 34, page 65, that would translate into 10% upper extremity (not whole person) impairment. Utilizing grip strength, however, is less than ideal, because not only is it under voluntary control, but also could be subconsciously diminished, and therefore, overestimates impairment, because of discomfort that will vary from time to time depending on the circumstances of that moment.
>
> There is no pathophysiologic mechanism to explain Mr. Wilcox's headaches and neck pain based on his elbow injury. There is no medical or other scientific evidence for the mechanism proposed by Dr. Caldwell, nor is there any evidence that Mr. Wilcox suffers from a radial nerve injury. From a temporal standpoint, the onset of his headaches is also not associated with the elbow injury. . . . I disagree with Dr. Caldwell's permanent impairment evaluation. There is no evidence of radial nerve dysfunction or injury. Mr. Wilcox has a full time work capacity limited by his subjective left elbow discomfort. It seems reasonable that he should avoid lifting more than 25 pounds with the left upper extremity alone on a frequent basis, avoid repetitive forceful grasping, as well as repetitive flexion and extension (pushing/pulling) with the left upper extremity. There would be no limits to his ability to walk, bend, twist, move his head, or use his lower extremities.

On January 5, 2004, the Claimant underwent an initial assessment at Protea Behavioral Health Services. (CX 35). After evaluation, the clinician noted that Mr. Wilcox was at risk for suicide or homicide during the time where he fears/expects foreclosure on his home. He further stated that, "[Mr. Wilcox] seems to have been quite talented in his profession and when this crisis period has passed and he has resolved some of the inherent loss/grief issues, may very well have the ability to redirect his life in a healthy, gratifying direction." The recommended therapy included supportive counseling, followed by psychotherapy to work on re-establishing his identity and sense of self-worth, followed by vocational rehabilitation.

On January 6, 2004, the Claimant was admitted for evaluation to Sebasticook Valley Hospital after he threatened "to blow someone's head off." A crisis team was called in and he was evaluated and ultimately transferred to the state mental hospital in Augusta. (CX 36, 37).

On January 8, 2004, Dr. William Brennan evaluated Mr. Wilcox for the Augusta Mental Health Institute. (CX 38). Upon examination, Dr. Brennan diagnosed Adjustment Disorder with Disturbance of Mood and Conduct. He recommended a "problem-focused treatment plan" and kept Mr. Wilcox on an involuntary basis until further assessment of his potential dangerousness could be evaluated. Mr. Wilcox was evaluated for one day and then released on January 9, 2004.

Dr. Bloom drafted a February 15, 2004 letter to Dr. John Garofalo updating Mr. Wilcox's condition. (CX 28). He described the Claimant as clam and reasonably optimistic about the future. The Claimant was taking prescription Remeron and was continuing counseling with a local counselor.

Dr. David J. Bourne completed a comprehensive psychiatric evaluation of Mr. Wilcox on February 19, 2004. Dr. Bourne reviewed the treatment records and noted the vocational training and history of Mr. Wilcox. In discussions with Mr. Wilcox, the Claimant, Dr. Bourne noted that the Claimant feels "he will lose everything if he cannot return to his usual type of work. He has never considered other vocations." Dr. Bourne opined that Mr. Wilcox has symptoms of depression and anxiety. He states:

> There clearly are psychological underpinnings for Mr. Wilcox's depression and anxiety which are independent of the work injury, but the effects of the work injury nevertheless have played a substantial role in causing his psychological deterioration. . . . Mr. Wilcox is a very needy person who has a poor self-image. . . . It was appropriate for Mr. Wilcox to have begun psychiatric treatment and it is appropriate for him to be continuing with a licensed therapist. It was also appropriate for him to be hospitalized for crisis intervention. It is my opinion that there is a significant causal connection between the work injury and Mr. Wilcox's psychiatric condition. . . . Despite his dissatisfaction with his current job, Mr. Wilcox is much better working than not. He is having a great deal of trouble adjusting to the fact that he is not performing his usual line of work, and still hopes to

> be able to be physically rehabilitated and to perform construction in the future. Given the chronicity of his physical problems, it may not be possible for him to achieve that level of activity in the future. It will take time for Mr. Wilcox to adapt to his not returning to his usual line of work. . . .

He opined that "Mr. Wilcox is much better working than not" and that he should continue to work "without psychiatric restrictions." In Dr. Bourne's opinion, Mr. Wilcox "retains the psychiatric capacity to be fully employed."

Maximum Medical Improvement:

The Claimant argues that "[a]lthough the arm part of his injury may have reached maximum medical improvement, the other sequelae of his injury including his shoulders, neck and psychiatric conditions has not." (Claimant's brief at 7). He points specifically, to Dr. Caldwell's October 20, 2003 report recommending treatment with a physiatrist, medications, possible trigger point injections or needling, pain and rest due to the Claimant's headaches and shoulder problems. (Id. at 8; See CX 29). He further argues that Dr. Bourne enumerated several types of recommended ongoing treatments to deal with the Claimant's psychological conditions. (Id.; See CX 39). Accordingly, the Claimant argues that his condition is not stable and that the nature of his injury at this point is temporary and not permanent. (Id.).

The Employer argues that the Claimant's arm injury has reached maximum medical improvement, and that the carrier has already paid an award for 12% permanent partial disability. It argues that the medical evidence shows that the Claimant's symptoms of recurrent headaches, shoulder and neck pain are not credible, and if credited, bear no causal relationship to the November 16, 2000 work incident. (Employer's brief at 5). Further, Claimant's psychological condition causes no meaningful disability and therefore, is not compensable. (Id.).

The determination of when maximum medical improvement ("MMI") is reached is primarily a question of fact based on medical evidence. Hite v. Dresser Guiberson Pumping, 22 BRBS 248 (1988). An administrative law judge must make a specific factual finding regarding MMI, and cannot merely use the date when temporary total disability is cut off by statute. Thompson v. Quinton Eng'rs, 14 BRBS 395, 401 (1981). Where the medical evidence indicates that the injured workers' condition is

improving and the treating physician anticipates further improvement in the future, it is not reasonable for an administrative law judge to find that MMI has been reached. Dixon v. John J. McMullen & Assocs., 19 BRBS 246, 245 (1986). Moreover, if a physician believes that further treatment should be undertaken, then a possibility of success presumably exists. Even if, in retrospect, it was unsuccessful, maximum medical improvement does not occur until the treatment is complete. Louisiana Ins. Guaranty Ass'n v. Abbott, 40 F.3d 122, 29 BRBS 22 (CRT) (5th Cir. 1994), aff'g 27 BRBS 192 (1993).

Arm Injury:

The parties agree that the original arm injury has reached maximum medical improvement. (Employer's brief at 5; Claimant's brief at 7). The remaining question, therefore, is when maximum medical improvement occurred on that injury. Dr. Van Orden opined on January 22, 2002, that the Claimant "probably has reached medical endpoint." (CX 23, p. 93). He continued to treat the Claimant however, throughout 2002. On December 13, 2002, Dr. Caldwell recommended further evaluation by a hand and arm specialist. (CX 20). On April 8, 2003, Dr. Fitz, the hand and arm specialist, recommended that the Claimant undergo nerve conduction studies to evaluate the possibility of radial tunnel syndrome. (CX 21). Finally, on October 30, 2003, Dr. Caldwell assigned the Claimant a 15% upper extremity impairment and recommended that the Claimant consult with a physiatrist to learn to deal with chronic pain. (CX 29, 41). Dr. Kolkin performed an evaluation only with no treatment to evaluate the Claimant's complaints of headaches and neck and shoulder pain, and opined that his examination revealed no neuropathy, and that the Claimant likely achieved maximum medical improvement of the arm injury at the time that his June, 2001, arm surgery healed, or somewhere around October, 2001. (CX 35). As Dr. Caldwell's October 30, 2003 evaluation was the last evaluation to deal directly with the arm injury, I find that maximum medical improvement of the arm occurred on October 30, 2003.

Neck and Shoulder Complaints:

The Claimant has the burden of proof to establish the existence of an injury in order to establish a *prima facie* case; Section 20 contains no presumption that claimant suffered an injury. Volpe v. Northeast Marine Terminals, 14 BRBS 17, 20 (1981), rev'd on other grounds, 671 F.2d 697, 14 BRBS 538 (2nd Circ. 1982); Young and Co. v. Shea, 397 F.2d 185, 188 (5th Cir. 1968), cert. denied, 395 U.S. 920 (1969). Section 2(2) of the

Act defines "injury" as "accidental injury or death arising out of and in the course of employment. . . ." The first documented discussion of the neck and shoulder complaints and accompanying headaches was made by Dr. Van Orden in his April 5, 2002 treatment notes. Dr. Van Orden reported that the Claimant "has had these headaches since some time after his surgery." The surgery took place on June 20, 2001. Dr. Michael Parks, an Ophthalmologist, found no vision related problems that could induce the headaches complained of by the Claimant. Dr. Caldwell opined that the injury to the left elbow has caused the myofascial problems and the headaches, but he gave no explanation or support for that diagnosis. He instead suggested that the Claimant consult with a hand and arm specialist. Dr. Fitz, a hand and arm specialist, diagnosed chronic tendonitis and possible radial tunnel syndrome. He suggested that the Claimant undergo nerve conduction studies to evaluate the radial tunnel syndrome. The nerve conduction studies were completed. Dr. Kolkin did a thorough neurological exam and could find no pathology to explain how the elbow injury related to the reported headaches. Dr. Caldwell incorporated all of this information to form his opinion that the Claimant suffered from 15% upper extremity impairment and that he had reached maximum medical improvement.

I find that the medical evidence does not establish a *prima facie* case of neck/shoulder and/or headache injury under the Act. The first documented incident of headaches was reported almost a year and a half after the work related injury to the elbow and arm. The Claimant has failed to tie the shoulder/neck pain and the headaches to his original injury by a preponderance of the evidence. Further, even if the reported pain could be proven as a work-related sequalae of the original injury, all physicians of record either found no medical cause for the neck/shoulder pain and headaches or they incorporated their belief that it was related to the original injury into their permanent disability rating. As such, it is already incorporated into the permanent disability ratings discussed above. No further injury adjustment is warranted, and these self-reported symptoms do not take the injury out of the schedule.

Psychological Problems:

As stated above, Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of and in the course of employment. . . ." The "arising out of employment" language of the Act refers to the causal connection between the

claimant's injury and an employment-related risk. Independent Stevedore Co. v. O'Leary, 357 F.2d 812 (9th Cir. 1966). Whether an injury arises out of one's employment refers to the cause of the source of the injury, Mulvaney v. Bethlehem Steel Corp., 14 BRBS 593 (1981), and the necessary causative nexus is established when there is "a causal relationship between the injury and the business in which the employer employees the employee – a connection substantially contributory though it need not be the sole or proximate cause." Cudahy Packing Co. v. Parramore, 263 U.S. 418, 423-24 (1923).

The Claimant argues that he sustained psychiatric sequelae to his work-related injury, which requires ongoing treatment, and which takes him out of the schedule and out of maximum medical improvement. (Claimant's brief at 9). The Claimant cites no case law in support of its position.

A psychological impairment can be an injury under the Act, if work related. Brannon v. Potomac Electric Power Co., 607 F.2d 1378, 10 BRBS 1048 (D.C. Cir. 1979). Psychological claims are generally successfully proven in two types of situations. The first involves stress- related claims where the stress of the job causes a mental breakdown and therefore, total disability. See e.g. Moss v. Norfolk Shipbuilding & Dry Dock Corp., 10 BRBS 428,431 (1979)(holding that stress of having to work overtime caused chest pains and therefore injury); Urban Land Institute v. Garrell, 346 F. Supp. 699 (D.D.C. 1972)(holding that where a nervous reaction was precipitated by stressful pressures of the job, no physical or external cause was necessary). The second involves a psychiatric disability following a work accident that prevents the Claimant from returning to work. See e.g. Dygert v. Manufacturer's Packaging Co., 10 BRBS 1036, 1043-44 (1979)(holding that claimant was totally disabled when there no medical pathology to explain the claimant's condition and all orthopedists and neurosurgeons agreed that the remaining condition was a psychological disability not a medical disability).

This Claimant's psychological condition does not fit into either type of claim. There has been no argument presented that the stress of performing Mr. Wilcox's job caused the Claimant's psychological problems. Nor does the medical evidence suggest that the Claimant suffers from a psychiatric disability. Dr. Bourne completed a comprehensive psychiatric evaluation of Mr. Wilcox and opined that "Mr. Wilcox is much better working than not" and that he should continue to work "without psychiatric restrictions." In Dr. Bourne's opinion, Mr. Wilcox "retains the

psychiatric capacity to be fully employed." As the Claimant's psychiatric conditions do not fit within the current case law and as the Claimant offers no support for its position, I find that the Claimant's psychological problems are not an injury or disability within the meaning of the Act.

The Claimant, therefore, reached maximum medical improvement on October 30, 2003.

Nature and Extent of the Injury/Disability:

Section 8 identifies four different categories of disability and separately prescribes the methods of compensation for each. Steevens v. Umpqua River Navigation, 35 BRBS 129 (2001). In the permanent partial disability category, Section 8(c) provides a compensation schedule which covers 20 different specific injuries, 33 U.S.C. § 8(c)(1)-(20), and an additional provision that applies to any injury not included within the list of specific injuries. 33 U.S.C. § 908(c)(21).

Permanent or Temporary Disability:

An injured worker's disability will be considered permanent if the employee's impairment has continued for a lengthy period and appears to be of a lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. Watson v. Gulf Stevedore Corp., 400 F.2d 649, 654 (5th Cir. 1968), cert denied 394 U.S. 976 (1969). See also Crum v. General Adjustment Bureau, 738 F.2d 474, 480 (D.C. Cir. 1984); Air America, Inc. v. Director, OWCP, 597 f.2d 773, 781-82 (1st Cir. 1979); Care v. Washington Metro. Area Transit Auth., 21 BRBS 248, 251 (1988). In such cases, the date of permanency is the date the employee ceases receiving treatment with a view toward improving his condition. Leech v. Service Eng'g Co., 15 BRBS 18, 21 (1982).

At the time of hearing, the Claimant's arm injury had been ongoing for a period of almost three years. Although the physicians of record differed on when they felt the elbow and arm injury had reached MMI, all eventually conceded that no further improvement was likely and that any further treatment should be focused on pain management and vocational rehabilitation and not upon improvement of the arm and elbow. I have previously found that Dr. Caldwell was the last physician to evaluate for further treatment and I have set an MMI date of October 30, 2003. I find that the Claimant has a permanent impairment, with an onset of permanency of October 30, 2003.

Total or Partial Disability:

The Employer has already paid 12% permanent partial disability under the schedule section 8(c)(1).

The scheduled permanent partial disability rates established by Sections 8(c)(1)-8(c)(20) of the Act are merely the minimum levels of compensation to which the injured employee is automatically entitled as a result of his injury and no proof of actual wage-earning capacity is required in order to receive at least the amount specified in the schedule of such injury. See Travelers Ins. Co. v. Cardillo, 225 F.2d 137 (2nd Cir. 1955); Greto v. Blakeslee, Arpaia & Chapman, 10 BRBS 1000 (1979). Determination of a disability in an adjudication of such claims must be based upon consideration of physical factors alone. Bachich v. Seatrain Terminals, 9 BRBS 184, 187 (1978). A worker entitled to permanent partial disability for an injury arising under the schedule may be entitled to greater compensation under Sections 8(a) and (b) by a showing that he is totally disabled. Potomac Elec. Power Co. v. Director, OWCP, 449 U.S. 268, 277 n.17, 14 BRBS 363 (1980); Davenport v. Daytona Marine & Boat Works, 16 BRBS 196, 199 (1984).

To establish a *prima facie* case of total disability, the Claimant must prove, by a preponderance of the evidence that he cannot return to his regular or usual employment due to his work related injury. The Claimant need not establish that he cannot return to any employment, rather only that he cannot return to his usual employment. Elliot v. C & P Tel. Co., 16 BRBS 89 (1984). If the Claimant satisfies this burden, he is presumed to be totally disabled. Walker v. Sun Shipbuilding & Dry Dock Co. (Walker II), 19 BRBS 171 (1986). The standards for determining total disability are the same regardless of whether temporary or permanent disability is claimed. Bell v. Volpe/Head Construction Co., 11 BRBS 377 (1979). The Act defines disability in terms of both medical and economic considerations. Avondale Shipyards, Inc. v. Guidry, 967 F.2d 1039 (5th Cir. 1992). The degree of the Claimant's disability, i.e. total or partial, is determined not only on the basis of physical condition, but also on other factors, such as age, education, employment history, rehabilitative potential and the availability of work. Thus, it is possible under the Act for a claimant to be deemed totally disabled even though he may be physically capable of performing certain kinds of employment. New Orleans (Gulfwide) Stevedore v. Turner, 661 F.2d 1031, 1038 (5th Cir. 1981).

As early as January 8, 2001, Dr. Van Orden noted that the Claimant was unable to swing his usual 23 ounce hammer. (CX 23, p. 50). On August 14, 2001, Dr. Van Orden limited the Claimant to sedentary work, lifting 10 pounds maximum. (CX 23, p. 74). On October 29, 2001, Dr. Van Orden questions whether the Claimant will ever be able to return to heavy construction work. (CX 23, p. 80). On December 10, 2001, Dr. Van Orden believes that the Claimant would be best served by vocational rehabilitation. (CX 23. p. 87). The Claimant's December 17, 2001 Functional Capacity Evaluation demonstrated great difficulty working in a sustained cold environment and great difficulty using vibratory tools without further risk of injury. The Evaluation also recommended vocational retraining to avoid further injury to the left arm. (CX 25). On January 22, 2002, Dr. Van Orden again suggests vocational retraining, noting that the Claimant is unlikely to be able to return to using a heavy hammer with remaining pain post surgery. (CX 23, p. 93). On July 8, 2002, Dr. Van Orden notes that Claimant is unlikely to be able to perform repetitive tasks (such as swinging a construction hammer) with the left arm. (CX 23, p. 107). Dr. Caldwell opined that the Claimant's pain is chronic and complicated and that the Claimant is capable of only light to moderate work activity. (CX 20). In Dr. Caldwell's final assessment, he opined that the Claimant can no longer perform work on ladders or unprotected heights, cannot operate vibratory or power tools, and cannot manipulate objects using a repetitive motion. (CX 29, 41). Upon review of the evidence of record, I find that the preponderance of such evidence is sufficient to establish a *prima facie* case of total disability as a result of the left arm injury that occurred on November 16, 2000.

If the Claimant makes this *prima facie* showing, the burden shifts to the employer to show suitable alternate employment. Clophus v. Amoco Prod. Co., 21 BRBS 261 (1988). A failure to prove suitable alternative employment results in a finding of total disability. Manigault v. Stevens Shipping Co., 22 BRBS 332 (1989); MacDonald v. Trailer Marine Trans. Corp., 18 BRBS (1986), *aff'd*, (No. 86-3444)(11th Cir. 1987)(unpub.). An employer must show the existence of realistically available job opportunities within the geographical area where the employee resides which he is capable of performing, considering his age, education, work experience, and physical restrictions, and which he could secure if he diligently tried.

The Employer has offered no argument nor presented evidence that suitable alternative employment exists. The only

employment evidence offered was presented by the Claimant, which showed that the Claimant was unable to perform the job of dishwasher at Simons Family Restaurant. The Claimant's father testified that he was "just making a job" without any real duties or obligations and has been paying his son a wage to help his son and his son's family out. The Employer has failed to show the existence of suitable alternative employment. As such, I find that the Claimant is totally disabled within the meaning of the Act.

Entitlement:

The evidence in record supports the conclusion that Ricky Wilcox was permanently totally disabled as a result of a work-related injury. I therefore find the Claimant entitled to temporary total disability compensation under §8(b) of the Act from November 27, 2000 until October 30, 2003, when he reached maximum medical improvement, in the amount of $666.76 per week, which is 66-2/3 percent of the Claimant's average weekly wage of $1001.14, as stipulated by the parties. I further find that the Claimant is entitled to total permanent disability compensation from October 30, 2003 forward, as defined by the Act. The Claimant is entitled to reimbursement for past medical expenses incurred for treatment of the original elbow/arm injury. Also, the Claimant is entitled, under § 7 of the Act, to future medical expenses incurred as a result of his job-related injury.

ORDER

Based on the Findings of Fact and Conclusions of Law expressed herein, IT IS HEREBY ORDERED that:

1. The Employer, Atkinson Construction Company, shall pay the Claimant, Ricky V. Wilcox, compensation for temporary total disability in the amount of $666.76 per week, for the period of November 27, 2000 until October 30, 2003, representing the period the Claimant was unable to work due to his disability, and based on the Claimant's average weekly wage of $1001.14, in accordance with the provisions of Section 8(b) of the Act. 33 U.S.C. § 908(b). All total temporary disability payments previously made by the Employer shall be credited against the amount due.

2. The Employer, Atkinson Construction Company, shall pay the Claimant, Ricky V. Wilcox, compensation for permanent total disability in the amount of $666.76

per week, from the period of October 30, 2003 forward, representing the period the Claimant is unable to work due to his disability, and based on the Claimant's average weekly wage of $1001.14, in accordance with the Act. 33 U.S.C. § 908(a). All total partial disability payments previously made by the Employer shall be credited against the amount due.

3. The Employer shall pay all reasonable, appropriate and necessary medical expenses arising from the Claimant's November 16, 2000, total disability, pursuant to the provisions of §7 of the Act.

4. The Employer shall pay interest on any sums determined to be due and owing at the rate provided by 28 U.S.C. § 1961 (1982); Grant v. Portland Stevedoring Co., et al., 16 BRBS 267 (1984).

5. The Claimant's attorney shall file, within thirty days of receipt of this Decision and Order, a fully supported and fully itemized fee petition, sending a copy thereof to Employer's counsel who shall have ten days to file objections. 20 C.F.R. § 702.132.

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DANIEL J. ROKETENETZ
Administrative Law Judge